



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
P O BOX 24809
HOUSTON TX 77029

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-3210-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Rule §134.202(4) [sic] A maximum of three FCE's for each compensable injury shall be billed and reimbursed. Reimbursement shall be for up to a maximum of 4 hrs for the initial test, 2 hours for an interim test; and 3 hours for a discharge test. FCE's shall be billed using the 'physical performance test or measurement..' CPT code with modifier FC."

Amount in Dispute: \$400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division records indicate the respondent was notified of the medical fee dispute on March 18, 2010. The response was due by March 31, 2010. As of the undersigned date, a response has not been received.

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2009	97750-FC	\$400.00	\$347.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §413.011(d-1) sets out the requirement for carriers to provide copies of contracts.
3. 28 Texas Administrative Code §134.204 sets out the medical fee guideline for workers' compensation specific

codes, services and programs provided on or after March 1, 2008.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 02, 2009, December 28, 2000

- (45) – Charges exceed your contracted/legislated fee arrangement.
- (W1) – Workers Compensation State Fee Schedule Adjustment
- * - This bill has been reviewed in accordance with your contract with MedRisk. All contracted Physical Therapy and-or Chiropractic charges should be billed through MedRisk at 2701 Renaissance Blvd., PO Box 61570, King of Prussia, PA. 19406...(I025)

Issues

1. Did the requestor have a contracted/legislated fee arrangement?
2. Does the submitted documentation support the services billed?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the Explanation of Benefits, the respondent denied reimbursement as contracted/legislated fee arrangement stating "This bill has been reviewed in accordance with your contract with MedRisk..." Texas Labor Code Annotated §413.011(d-3) states that the Division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the Division's Fee Guidelines if the contract is not provided in a timely manner to the Division. On September 22, 2010, the respondent was asked for a copy of the contract between the informal/voluntary network and the requestor. The Division also requested documentation to support that the requestor was notified in accordance with 28 Tex. Admin. Code §133.4. The respondent failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed in accordance with §134.204.
2. Review of the submitted documentation supports the services were rendered as billed, and are therefore payable under 28 Texas Administrative Code §§134.204(g) and 134.203(c)(1).
3. The requestor is entitled to reimbursement. The requestor billed \$400.00 for 8 units for code 97750-FC. Reimbursement is calculated as: $53.68(\text{WC CF}) \div 36.0666(\text{MC CF}) = 29.20(\text{MC Participating Amount}) = \$43.46 \times 8 \text{ units} = \347.68 .

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$347.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$347.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Pat DeVries

Medical Fee Dispute Resolution Officer

October 20, 2011

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.